

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 05/01/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2325 NORTH LAKewood AVENUE CHICAGO, IL 60614</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments  Investigation of Facility Reported Incident of January 12, 2025/IL190754	S 000		
S9999	Final Observations  Statement of Licensure Violations: 300.610a) 300.1210b)4)5) 300.1210c) 300.1210d)6)   Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.   Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

05/21/25

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 05/01/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2325 NORTH LAKewood AVENUE CHICAGO, IL 60614</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 1</p> <p>care needs of the resident.</p> <p>4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.</p> <p>5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to properly transfer a resident (R1) using a</p>	S9999		

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 05/01/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2325 NORTH LAKWOOD AVENUE CHICAGO, IL 60614</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>mechanical lift during bedside care. This failure affected one resident (R1) causing R1 to sustain a fracture of the distal shaft of the fifth metatarsal and pain in left hand fifth metatarsal.</p> <p>Findings include:</p> <p>R1 has a diagnosis which includes but are not limited to unspecified abnormalities of gait and mobility and paralytic gait.</p> <p>R1 has a Brief Interview of Mental Status (BIMS) dated 03/17/25 documents that R1 has a BIMS score of 08 which indicates that R1 has some cognitive impairments.</p> <p>R1's Initial/Final Report to the surveying state agency dated 01/15/25 at 8:05 am documents in part: "Date, Time, location of Injury: 01/12/2025, 3:50 pm, Residents bedroom. Based on the initial and final investigation, review of the medical record, and interview of witnesses during the event, the following are the known facts at this time on 1/12/2025 at 3:50 pm, nurse informed by CNA (Certified Nursing Assistant) that when transferring from the bed to chair, resident was trying to grab armrests of wheelchair when her left fifth small finger was bent against the armrest. During the investigation, CNA stated that she was transferring the resident from bed to wheelchair with the help of another CNA when they noticed left fifth small finger was bent against the armrest. When asked if she's ok, resident held her hand up and pointed to her left fifth small finger stating, "dolor" meaning pain in Spanish. Nurse on duty immediately notify physician and POA (Power of Attorney). Order to apply ice to the affected area and give Tylenol PRN (as needed). On 1/14/25 resident verbalized increased pain to the area. Upon assessment, nurse on duty notice slight</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 05/01/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2325 NORTH LAKewood AVENUE CHICAGO, IL 60614</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>swelling to left hand. Area around the fifth small finger was warm and sensitive to touch. Physician was notified with an order for X-ray of left hand in X-ray result later revealed fracture of the 5th metatarsal. Nurse immediately notified MD (Medical Doctor) with order given to, buddy tape of injured finger and second finger together, OT (Occupational Therapy) evaluation and treatment, then repeat X-ray in three weeks."</p> <p>The facility's document dated 01/12/25 authored by V11 (Registered Nurse/RN) shows R1's Incident Description and documents, in part: "Was informed by CNA (Certified Nursing Assistant) that when transferring from bed to chair, resident was trying to grab armrest of wheelchair when her left fifth small finger was bent against the armrest."</p> <p>On 04/28/25 at 11:45 am, R1 stated that she had an injury to her finger however, R1 does not recall what happened in detailed and could not explain to surveyor how the injury occurred on 01/12/25. R1's hand was observed without bruising or swelling and R1 denied pain to R1's left hand fifth finger at this time.</p> <p>On 04/28/25 at 1:11 pm, V6 (CNA) stated that V6 was assigned to R1 on 01/12/25 the day of R1's injury to her left hand fifth finger. V6 explained that she and V7 (CNA) was performing a pivot transfer with R1 without a gait belt or mechanical lift. V6 explained that she and V7 was positioned on each side of R1 while V7 was holding onto the back of R1's pants, V6 was holding underneath R1's right arm and R1 was holding onto R1's wheelchair. V6 then explained that she thinks R1 snapped her left hand fifth finger while R1 was holding onto R1's wheelchair. V6 further explained that once she and V7 transferred R1 to</p>	S9999		

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 05/01/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2325 NORTH LAKewood AVENUE CHICAGO, IL 60614</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 4</p> <p>her wheelchair, R1 was holding her left hand 5th finger and showing V6 her (R1) fifth finger with facial grimaces. V6 then informed R1's nurse that R1 was holding her (R1's) 5th finger and grimacing. V6 denied that she observed swelling, bruising or obvious deformities to R1's left hand fifth finger. V6 explained that R1 is a (mechanical lift) transfer and that R1 uses a wheelchair for ambulation. V6 then explained that V6 and V7 did not use a gait belt or a mechanical lift because V6 felt that R1 could stand and transfer without it. V6 explained during R1's transfer, V6 last saw R1's hand holding onto R1's wheelchair armrest during R1's transfer from bed to chair and that V6 assumed that R1's left hand fifth finger must have gotten caught on R1's wheelchair during V6 and V7's transfer of R1 from bed to chair.</p> <p>On 04/28/25 at 1:30 pm, V7 (CNA) stated that V6 and V7 was transferring R1 from bed to chair around 3:30 pm, on 01/12/25. V7 explain that R1 lay down for a nap around 1:30 pm, every day and staff will get R1 out of bed again around 3:30 pm, daily. V7 further explained that she and V6 (CNA) was transferring R1 from R1's bed to R1's wheelchair after R1's had taken a nap. V7 stated that R1 is (mechanical lift) however she and V6 did not use a gait belt or mechanical lift to transfer R1 that day. V7 stated that she stood behind R1 holding R1's pants and V6 stood to the right side of R1 holding R1's arms. V7 then explained during the transfer that R1 went to grab R1's chair to stand and when V7 and V6 pivoted R1 to her wheelchair, R1 held onto to her wheelchair with both hands facing her wheelchair before she released her left hand to place it onto the right side of the armrest. V7 stated after R1 sat down R1 was holding R1's fifth finger speaking in Spanish and V7 figured R1 was complaining of pain because of how R1 was holding R1's fifth</p>	S9999		

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 05/01/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2325 NORTH LAKewood AVENUE CHICAGO, IL 60614</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 5</p> <p>finger and was speaking while showing V7 and V6 her (R1's) finger. V7 stated that she looked at R1's finger and did not see any redness or injuries and then she took R1 to V11 (Agency RN) to inform V11 of R1's injury. V7 stated that she does not recall the next time she cared for R1 after that day.</p> <p>On 04/29/25 at 10:25 am, V11 (Agency RN) stated that V11 is agency nurse who frequently has worked at the facility for over one year and that V11 is familiar with R1. V11 stated that she recalls R1's injury on 01/12/25. V11 explained that on the evening shift a little after 3:00 pm, two CNAs informed V11 that R1 sustained an injury to R1's finger during a transfer. V11 explained that V6 (CNA) and V7 (CNA) stated that R1 tried to grab hold of R1's armrest on R1's wheelchair and that R1's left hand fifth finger got caught on the armrest of R1's wheelchair and injured R1's finger. V11 stated that she assessed R1's finger in the hallway and that R1's finger looked okay. V11 then explained that R1 was complaining of pain to R1's left hand fifth finger. V11 stated that she then phoned V15 (R1's Physician) and informed V15 of R1's injury. V11 stated that V15 ordered an ice pack and for R1 to be given Tylenol for pain. V11 stated that she administered R1 Tylenol and rechecked the effectiveness of the Tylenol that was administered to R1 around 7:00 pm. V11 then stated that R1 denied pain to R1's fifth finger and that R1's finger was a little pink but not swollen at that time. V11 stated that V11 did not assess R1's finger anymore during V11's shift that day and did not work with R1 for a few days after that. V11 stated that she was told that the physician ordered an X-ray of R1's fifth finger a few days after R1's injury when R1's finger began to bruise and swell.</p>	S9999		

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 05/01/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2325 NORTH LAKewood AVENUE CHICAGO, IL 60614</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 6</p> <p>On 04/29/25 at 12:00 pm, V2 (Director of Nursing/DON) stated that V2 is currently the DON and Restorative Nurse for the facility. V2 stated that she recalled being called on 01/12/25 regarding R1 having an injury to R1's finger when R1's was being transferred. V2 stated that she spoke with V6 (CNA) and V7 (CNA) and that V6 and V7 stated that R1 was holding the arm rest of her wheelchair during a transfer when R1's finger got caught on armrest of her wheelchair. V2 explained that V17 (Facility's Previous Restorative Nurse) who no longer works at the facility since February 14, 2025, informed staff that R1 had two transfer statuses and that R1 could transfer manually with two staff if R1 was able to stand and that R1 required a mechanical lift with two staff if R1 is shaking to much from R1's Parkinson's. V2 then explained, if a resident is dependent for transfers or requires maximum assistance for transfers, the resident should be transferred with a mechanical lift. V2 further explained that if a resident is not dependent for transfers and staff are transferring the resident without a mechanical lift that the staff (CNAs) should be transferring a resident using a gait belt. V2 then explained that the CNAs should reference the resident care plan task and the POC (Plan of Care) for the resident's transfer status. V2 stated that physical therapy determines the residents initial transfer status and that the restorative nurse then maintains the residents transfer status or refer the resident back to therapy if the resident declines. V2 also explained that the resident's transfer status is on the resident's care plan. V2 stated that R1 transfer status is a mechanical lift and that V2 thinks the staff was previously confused regarding what R1's transfer status at the time of R1's injury on 01/12/25. V2 stated that if staff do not know a resident's transfer status or does not transfer the</p>	S9999		

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 05/01/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2325 NORTH LAKewood AVENUE CHICAGO, IL 60614</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 7</p> <p>resident according to the resident plan of care transfer status the staff and/or resident can suffer an injury. V2 further explain that the facility received R1's initial X-ray report around 3:00 am on 01/14/25 that documented that R1's left hand was negative for fracture. V2 then explained that around noon the next day the facility received a second radiology report that stated that R1 had a fracture to the left fifth finger. V2 stated that she called the X-ray company and the X-ray company explained that the results initially were no fracture before the physician reviewed the X-ray and the X-ray physician stated that R1 sustained a fracture of the left hand fifth finger. V2 stated that the X-ray company stated they tried calling the facility regarding the updated X-ray results and was not able to speak with a staff member. V2 denied any nurses stating that they received a call from X-ray company with fracture results. V2 stated after receiving R1's X-ray results that R1 had a fracture of the left fifth metatarsal, R1's left hand was placed in a splint until repeat X-ray shows that R1's left hand fifth finger fracture was healed.</p> <p>On 04/30/25 at 9:40 am, V15 (R1's Physician) stated that V15 is the physician for R1 and last saw R1 about one month ago at the facility. V15 recalls R1 having an incident injuring R1's finger a few months ago. V15 stated that staff informed V15 that R1 bumped R1's finger on a railing during a transfer and that R1's finger was swollen. V15 explained that V15 ordered ice to be applied and for R1 to be medicated for pain due to R1's injury to the left-hand finger. V15 further explained that he visits the facility on Tuesdays and Thursdays and informed staff that V15 would examine R1 on the next Tuesday or Thursday's visit to the facility. V15 stated that he assessed R1's left hand fifth finger a few days after the</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 05/01/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2325 NORTH LAKewood AVENUE CHICAGO, IL 60614</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 8</p> <p>injury occurred and ordered and X-ray. V15 stated that R1's X-ray revealed R1 had a fractured finger and R1 was placed in a splint until the injury healed on its own. V15 stated that R1 requires maximum assistance's during transfers due R1's Parkinson's disease. V15 stated if R1 is care planned to use a mechanical lift such as (name of mechanical lift) staff should be using the mechanical lift during transfers. V15 also stated that in V15's professional opinion staff should be using mechanical lifts according to the resident's care plan for the safety of the staff and the resident. V15 then stated if a resident is care planned to use a mechanical lift and staff does not use the mechanical lift the resident can have a fall or sustain an injury.</p> <p>R1's Care Plan dated initiated 08/03/22 documents, in part: "ADL (Activities of Daily Living) R1 is self-care performance deficit due to muscle stiffness, abnormalities of gait and poor coordination related to Parkinson disease. Transfer: R1 requires (name of mechanical lift) and extensive assist of two CNAs nursing staff with functional transfers to from bed and wheelchair. Explain task to our one prior to starting tasks and get her cooperation. Make sure the straps for the back and legs are applied correctly and secured. With extensive assistance of two nursing staff transfer R1 from bed and wheelchair."</p> <p>R1's Minimum Data Set (MDS) dated 12/16/24 shows that R1 is dependent for (name of mechanical lift) and chair/bed-to-chair transfer."</p> <p>R1's progress note dated 01/12/25 at 3:50 pm, authored by V11 (RN) documents in part: " CNAs (Certified Nursing Assistant) and form nurse on duty resident sustained injury to small finger of</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 05/01/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2325 NORTH LAKewood AVENUE CHICAGO, IL 60614</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 9</p> <p>left hand on transfer from bed to chair. On assessment it was void of redness or swelling and she was able to move the finger but with pain displaying facial grimaces, and in her native language saying "dolor" meaning pain. Vital signs taken were normal limits."</p> <p>R1's progress note dated 01/18/25 at 3:07 pm, authored by V5 (RN) documents, in part: "resident wearing immobilizer to left hand for 5th and 4th fingers. Ice applied to help with pain and swelling. Patient requires assistance with ADL's (Activities of Daily Living). Resident is a two person assist with (mechanical lift) transfer. Resident on skilled OT (Occupational Therapy) or self-care, caregiver education, therapeutic activity, therapeutic exercise, neuromuscular re-education, wheelchair management and splint/orthotic management."</p> <p>R1's progress note dated 01/18/25 at 6:36 am, authored by V11 (RN) documents, in part: "left hand owner gutter splint to be on at all times except for hygiene until healed. Splint in place at this time resident did not remove during the night. No swelling or color change noted at this time period no complaint of pain."</p> <p>R1's Radiology Results Report dated 01/14/25 AT 13:10 pm, documents, in part: " Left Hand: examination reveals mild soft tissue swelling with oblique fracture of the distal shaft of the 5th metatarsal with no significant displacement ... Impression: Left hand fracture of the left 5th metatarsal."</p> <p>The facility's policy dated 08/2017 and titled "Transfer and Lifting" documents, in part: "Purpose: To ensure the safety of both staff and residents ... 5. The designated method of lifting</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 05/01/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2325 NORTH LAKewood AVENUE CHICAGO, IL 60614</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 10</p> <p>and transferring of a resident is indicated in a residents care plan and (name of documentation system)."</p> <p>The facility's policy dated 08/2017 and titled "Mechanical Lift, Use of" documents, in part: "Policy 1. The facility wasn't to ensure that the residents are cared for safely while maintaining a safe work environment for employees. 2. Nursing staff member will assess each resident prior to transferring them to determine the safest way to accomplish the transfer ... Purpose To ensure that all nursing staff members use safe handling and moving techniques on all residents during transfers with the mechanical lifts. Use of Mechanical Lift 1. A mechanical lift can be used to transfer a resident who cannot transfer independently."</p> <p>The facility's undated job description titled "Certified Nursing Assistant" document, in part: "Job Description: Summary/Objective: The Certified Nursing Assistant performs routine resident care duties delegated by the registered nurse or licensed practical nurse who supervises the individual for the direct care of a resident. The certified nursing assistant students with their personal needs and caring including mobility in accordance with comprehensive assessment and plan of care ... Essential functions: ... 3. Observe and report to nurse any changes or observations in residence behavior and physical status and adapt to these changes providing the safest care. Follow instructions and report back when necessary. Seek guidance using the proper channels of communication ... 8. Recognize and respond appropriately to unsafe environmental conditions and to emergency situations. 9. Use proper body mechanics. Demonstrate appropriate techniques and walking, use of lifts, transferring,</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 05/01/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2325 NORTH LAKewood AVENUE CHICAGO, IL 60614</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 11</p> <p>positioning, and transporting residents. Consistent use of gait belt according to the home's policy/ procedure guidelines ... Restorative Services: ... 14. Display ability to perform restorative services including Apply/ use assistive devices for ambulation, eating, and dressing; maintenance of range of motion, proper turning, positioning, transferring, bowel and bladder training, care, and use of prosthetic devices ... Miscellaneous: ... 20. Follow all safety, security, exposure control and hazardous waste policies and procedures."</p> <p>"B"</p>	S9999		